State-Unique and Selected HCPCS Procedure Codes

MAA has moved the fees for all reimbursable HCPCS codes and state-unique codes to the complete list of procedure codes and maximum allowable fees. All state-unique procedure code descriptions and limitations, and those HCPCS codes with special limitations or requirements, are listed below. However, this list may not be all-inclusive. Limitations or requirements detailed in MAA's billing instructions and/or WAC remain applicable.

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting
Developmental Disabilities Program		
0310M	Annual physical exam (Use diagnosis code V93.0)	$103.99
Tuberculosis Treatment Services		
9011M	Initial TB examination	$35.87
9012M	Follow-up TB examination	$21.37
AIDS Counseling Services		
9020M	Risk factor reduction intervention for HIV/AIDS clients only one precounselinng session and one postcounseling session (Use diagnosis code V65.9 if lab test results are negative.)	$27.63
Detox		
0025M	Detox physician care - admission	$40.50
0026M	Detox physician care – follow-up	$20.25
EPSDT		
0252M	Interperiodic screening	$18.70
Clozaril		
0857J	Clozaril case coordination	$10.57

Anesthesia

Effective for dates of service on and after July 1, 2002, state-unique codes 5911M – 5915M have been discontinued and replaced with CPT codes. Please refer to Section F for the appropriate coding.

Cast Materials Only – Plaster or Fiberglass

The reimbursement for cast materials is based on the size and number of rolls used in preparing a cast instead of the type of cast prepared. The maximum allowable fees are for the cost of one roll and whether the cast was fiberglass or plaster. When billing, use the procedure code for the size of rolls and the number of each used. Below are the procedure codes that should be used when billing for cast materials:

2978M	Fiberglass, 2" x 4 yd roll	$9.00
2979M	Fiberglass, 3" x 4 yd roll	$11.00
2980M	Fiberglass, 4" x 4 yd roll	$14.25
2981M	Fiberglass, 5" x 4 yd roll	$16.56
2982M	Plaster, 2" x 3 yd roll	$1.35
2983M	Plaster, 3" x 3 yd roll	$1.75
2984M	Plaster, 4" x 5 yd roll	$2.65
2985M	Plaster, 5" x 5 yd roll	$3.00
2986M	Plaster, 6" x 5 yd roll	$3.50
2987M	Plaster, 8" x 5 yd roll	$3.75

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting

Maternity Care And Delivery

5930M	Initial prenatal assessment; includes medical history, physical examination, and identification of risk factors	$50.00
5941M	High-risk vaginal delivery, add-on fee (to be used by delivering physician only)	$282.61
5935M	Labor management	$282.61
5947M	Antepartum and postpartum care and assist at cesarean section **(do not use modifier 80)**	$1,039.52
5951M	Routine antepartum care, first and second trimester, per month	$74.31
5952M	Routine antepartum care, third trimester, per month	$126.28
5953M	High-risk management, first trimester, add-on, per month	$30.55
5954M	High-risk management, second trimester, add-on, per month	$37.84
5955M	High-risk management, third trimester, add-on, per month	$91.18
Note:	Bill one unit per calendar month. Use a separate detail line for each calendar month, indicating the date of service. If you perform total obstetrical care including antepartum, delivery and postpartum, you may bill one of the global obstetric codes.	
5959M	High-risk cesarean section, add-on fee	$282.61

Laboratory Stat

Effective for dates of service on and after July 1, 2002, state-unique code 8949M is discontinued and replaced with HCPCS code S3600.

S3600	Stat lab request	$3.35

Radiology

7612M	Transportation and set-up of portable radiologic equipment; at bedside or in operating room not otherwise specified **(Included in DRG for inpatient services. Outpatient services are payable by special agreement only.)**	$8.74
7698M	Transportation and set-up of portable equipment, ultrasound, bedside or operating room **(Included in DRG for inpatient services. Outpatient services are paid by special agreement only.)** For each additional patient, use R0075.	B.R.
R0070	Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location; one patient seen ***(MAA's fee includes set-up)***	$43.69
R0075	Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location; more than one patient seen, per patient ***(MAA's fee includes set-up)***	$14.19
R0076	Transportation of portable EKG to facility or location, per patient (payable only with 93000 or 93005) ***(MAA's fee includes set-up)***	Bundled

Surgery

4693M	Infared coagulation internal hemorrhoids	
	Non-facility	$131.95
	Facility:	$78.49

Physical Medicine

0002M	Custom splint (cockup and/or dynamic)	$47.76

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting

Family Contraceptive Management

J1055	Depro Provera, 150 mg contraceptive injection; allowed once every 65 days.	$49.99

Effective for dates of service on and after May 1, 2002, state-unique code 1111J for Lunelle has been discontinued and replaced with HCPCS code J1056.

J1056	Lunelle, monthly contraceptive injection; allowed once every 23 days	$24.02
1112J	Emergency Contraception Pills (ECP)	Acquisition Cost

Norplant/IUC/Diaphragm

A4260	Levonorgestrel (contraceptive) implants systems, including implants & supplies *One Norplant System allowed in 5 years.*	$451.68

Effective for dates of service on and after July 1, 2002, state-unique code 9911M for a non-copper IUD is discontinued and replaced with HCPCS code S4989.

S4989	Intrauterine device (Progestacert) (For intrauterine copper contraceptive device, see J7300)	$116.31
9912M	Diaphragm	$45.00

Effective for dates of service on and after July 1, 2002, state-unique code 9913M for Mirena IUD is discontinued and replaced with HCPCS code J7302.

J7302	Mirena IUD	$355.50
A4261	Cervical cap for contraceptive use	$47.00

Drug-Induced Abortions (RU-486)

S0190	Mifeprestone, oral, 200 mg	$80.10
S0191	Misoprostol, oral, 200 mcg	$0.96

Psychiatry

9089M	Certification activities related to elective inpatient psychiatric admission for clients younger than 21 years of age to an inpatient psychiatric facility. Billed by a member of a certification team (e.g., physician, psychiatrist).	$66.71
0070M	Psychological evaluation	$67.80

Involuntary Treatment Act (ITA)

9083M	Involuntary Treatment Act physical exam	$36.12
9084M	Involuntary Treatment Act psychiatric admission and evaluation	$94.26
9085M	Involuntary Treatment Act court testimony, under 20 minutes	$19.76
9086M	Involuntary Treatment Act court testimony, 20-50 minutes	$29.97
9087M	Involuntary Treatment Act court testimony, over 50 minutes	$49.42

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting

Ophthalmology

9274M	Materials used for glasses repair (specify materials billed)	$15.17
9275M	Fitting (including dispensing) fee for therapeutic bandage lenses. **(Including 14-day follow-up care.)**	$123.53
9276M	Fitting (including dispensing) fee for contact lenses. **(Including 30-day follow-up care for training period.)**	$46.33
9277M	Fitting of contact lenses for treatment of disease. **(Including 90-day follow-up care.)**	$140.75

Cardiography

9301M	Computer-simulated ECG with interpretation and report	$12.68
9302M	Transmission and assimilation only	$3.69
9303M	Over-reading (interpretation) and report only	$9.28

Application of Fluoride Varnish (physician and ARNPs)

0122D	Application of fluoride varnish (Physician and ARNPs). Allowed 3 times in a 12-month period for children 18 years of age and younger.	$18.93

Hyalgan/Synvisc **(See page C17 for policy)**

J7316	Sodium Hyalruonate, 5 mg, for intra-articular injection (Hyalgan) ***Maximum of 5 injections** ***Maximum of 20 units** ***5 mg = one unit**	$26.12
J7320	Hylan G-F 20, 16 mg, for intra-articular injection (Synvisc) ***Maximum of 3 injections.** ***One injection = one unit**	$209.15

Verteporfin

J3395	Injection, verteporfin, 15 mg **Limited to ICD-9 diagnosis code 362.52 (exudative senile macular degeneration)**	$1,366.15

Indwelling Catheter

G0002	Insertion, temporary indwelling catheter, Foley type • Payable only when performed in an office setting; • Not allowed if performed on the same day as a major surgery; • Not allowed if performed during the post-operative period of a major surgery.	$88.04

Neurology

9593M	F-wave-auditory brainstem	$28.42

Vestibular Function Test, With Recording (e.g., ENG, PENG, And Medical Diagnostic Evaluation)

9254M	Electronystamographic testing, complete with recording and interpretation (ENG)	$104.47

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting	Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting

Podiatry/Orthotics

1600L Single fabricated orthotic $61.85
- ***Must include modifier RT or LT.***
- *Limited to 2 units per client, per calendar year.*
- *Limited to 1 unit per date of service.*
- *Do not bill in combination with 1601L or 1603L.*

1601L Pair fabricated orthotic $111.20
- *Must include fabrication for both right and left feet.*
- *Limited to 1 unit per calendar year.*
- *Do not bill in combination with 1600L or 1603L.*

1602L Impression casting, each foot $43.80
- ***Must include modifier RT or LT.***
- *Limited to 2 units per client, per calendar year.*
- *Limited to 1 unit per date of service.*
- *Do not bill in combination with 1604L.*

1603L Prefabricated orthotic B.R.
(attach invoice if over $50.00)
- ***Must include modifier RT or LT.***
- *Limited to 2 units per client, per calendar year.*
- *Do not bill in combination with 1600L or 1601L.*

1604L Impression casting, custom shoes, pair $150.96
- *Must include fabrication for both right and left feet.*
- *Limited to 1 unit per calendar year.*
- *Do not bill in combination with 1602L.*

MAA reimburses podiatrists for state-unique codes 1600L, 1602L, and 1603L only when they are billed with one of the following modifiers: (RT) or (LT).

NOTE: Orthotic fees include dispensing. Any other procedure codes for prosthetic/orthotics must be billed using a prosthetic/orthotic provider number.

This is a blank page.

Bundled Services Not Paid Separately

☞ **NOTE: MAA is currently in the process of evaluating and adopting Medicare's Correct Coding Initiative (CCI) policies and edits. Therefore, any procedures or services that are currently bundled by Medicare are bundled by MAA, as well.**

Supplies Included in Office Call (Bundled Supplies)

Note:

*Items with an asterisk on the following list are considered prosthetics when used for a **permanent** condition. They may be paid for permanent conditions if they are provided in the physician's office. They are not considered prosthetics if the condition is acute or temporary. Please indicate on the claim if billing for a permanent condition.

Examples would be Foley catheters and accessories for permanent incontinence or ostomy supplies for permanent conditions. The Foley catheter used to obtain a urine specimen, used after surgery, or used to treat an acute obstruction would not be paid separately because it is treating a temporary problem. If a patient had an indwelling Foley catheter for permanent incontinence, and a problem developed for which the physician was required to replace the Foley, then the catheter would be considered a prosthetic and would be paid separately.

HCPCS Code	Description
A4206	Syringe with needle, sterile 1cc
A4207	Syringe with needle, sterile 2cc
A4208	Syringe with needle, sterile 3cc
A4209	Syringe with needle, sterile 5cc
A4211	Supplies for self-administered injections
A4212	Huber-type needle, each
A4213	Syringe, sterile, 20 CC or greater
A4214	Sterile saline or water, 30 CC
A4215	Needles only, sterile, any size
A4220	Refill kit for implantable infusion pump
A4244	Alcohol or peroxide, per pint
A4245	Alcohol wipes, per box
A4246	Betadine or phisohex solution
A4247	Betadine or iodine swabs/wipes
A4253	Blood glucose test
A4256	Normal, low and high cal solution
A4258	Spring-powered device for lancet, each
A4259	Lancets, per box
A4262	Temporary lacrimal duct implant, each
A4263	Permanent lacrimal duct implant, each
A4265	Paraffin, per pound
A4270	Disposable endoscope sheath, each
A4300	Implantable access partial/catheter
A4301	Implantable access total system
A4305	Disposable drug delivery system, flow rate 50 ML or more per hour

HCPCS Code	Description
A4306	Disposable drug delivery system, flow rate 5 ML or less per hour
A4310	Insertion tray w/o drainage bag
A4311	Insertion tray without drainage bag
A4312	Insertion tray without drainage bag
A4313	Insertion tray without drainage bag
A4314	Insertion tray with drainage bag
A4315	Insertion tray with drainage bag
A4316	Insertion tray with drainage bag
A4320	Irrigation tray for bladder
A4322	Irrigation syringe, bulb or piston
A4323	Sterile saline irrigation solution
A4326*	Male external catheter
A4327*	Female external urinary collection metal cup, each
A4328*	Female external urinary collection pouch, each
A4329*	External catheter starter set
A4330	Perinal fecal collection pouch
A4335*	Incontinence supply; miscellaneous
A4338*	Indwelling catheter; Foley type
A4340*	Indwelling catheter; Spec type
A4344*	Indwelling catheter; Foley type
A4346*	Indwelling catheter; Foley type
A4347*	Male external catheter
A4351	Intermittent urinary catheter
A4352	Intermittent urinary catheter
A4353	Catheter insert tray with cath/tube/bag
A4354	Insertion tray with drainage bag
A4355	Irrigation tubing set
A4356*	External urethral clamp device
A4357*	Bedside drainage bag, day or night
A4358*	Urinary leg bag; vinyl
A4359*	Urinary suspensory, without leg bag
A4361*	Ostomy faceplate
A4362*	Skin barrier; solid, 4 x 4
A4364*	Adhesive for ostomy or catheter
A4365*	Ostomy bag, disposable, closed
A4367*	Ostomy belt
A4368*	Stoma wicks, each
A4397	Irrigation supply; sleeve
A4398*	Irrigation supply; bags
A4399*	Irrigation supply; cone/catheter
A4400*	Ostomy irrigation set
A4402	Lubricant
A4404*	Ostomy rings
A4421*	Ostomy supply; miscellaneous
A4454	Tape, all tapes, all sizes
A4455	Adhesive remover or solvent
A4460	Elastic bandage
A4465	Non-elastic binder for extremity
A4470	Gravlee jet washer
A4480	Vabra aspirator
A4550	Surgical tray

CPT Code	Description
A4556	Electrodes (e.g., apnea monitor)
A4557	Lead wires (e.g., apnea monitor)
A4558	Conductive paste or gel
A4647	Supply of paramagnetic contrast material (e.g., gadolinium)
A4649	Surgical supply; miscellaneous
A5051*	Pouch, closed; with barrier
A5052*	Pouch, closed; without barrier
A5053*	Pouch, closed; use on faceplate
A5054*	Pouch, closed; use on barrier
A5055*	Stoma cap
A5061*	Pouch, drainable; with barrier
A5062*	Pouch, drainable; without barrier
A5063*	Pouch, drainable; use on barrier
A5064*	Pouch, drainable; with faceplate
A5071*	Pouch, urinary; with barrier
A5072*	Pouch, urinary; without barrier
A5073*	Pouch, urinary; use on barrier
A5074*	Pouch, urinary; with faceplate
A5075*	Pouch, urinary; use on faceplate
A5081*	Continent device; plug
A5082*	Continent device; catheter
A5093*	Ostomy accessory; convex insert
A5102*	Bedside drainage bottle
A5105*	Urinary supensory; with leg bag
A5112*	Urinary leg bag; latex
A5113*	Leg strap; latex, per set
A5114*	Leg strap; foam or fabric
A5119*	Skin barrier; wipes, box per 50
A5121*	Skin barrier; solid, 6 x 6
A5122*	Skin barrier; solid, 8 x 8
A5123*	Skin barrier; with flange
A5126*	Adhesive; disc or foam pad
A5131*	Appliance cleaner
A6020	Collagen based wound dressing
A6021	Collagen dressing <=16 sq in
A6022	Collagen drsg>6<=48 sq in
A6023	Collagen dressing >48 sq in
A6024	Collagen dsg wound filler
A6025	Silicone gel sheet, each
A6154	Wound pouch, each
A6231	Hydrogel dsg <=16 sq in
A6232	Hydrogel dsg>16<=48 sq in
A6233	Hydrogel dressing >48 sq in
G0025	Collagen skin test kit
99070	Special supplies (CPT code)

Office Procedures That Are Billable With Procedure Code A4550

☞ **NOTE: Effective for dates of service on and after July 1, 2002, Medicare has bundled HCPCS code A4550 into the appropriate procedures. The relative value units (RVUs) of those procedures have been adjusted to take into account the cost of the surgical trays. Therefore, HCPCS code A4550 is no longer separately payable.**

Supplies Reimbursed Separately When Dispensed from Physician's Office

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting
A4250	Urine test or reagent strips	Acquisition Cost

Effective for dates of service on and after July 1, 2002, HCPCS codes A4263 and A4300 are bundled.

~~A4263~~	~~Permanent, long-term, non-dissolvable lacrimal duct implant, each. In order to receive payment for this supply, it must be billed with the CPT code 68761, closure of lacrimal pumctum; by plug, each.~~	
~~A4300~~	~~Implantable vascular access partal/catheter. In order to receive payment for this supply, it must be billed with CPT code 36533, insertion of implantable venous access part, with or without subcutaneous reservoir.~~	

Braces, Belts, And Supportive Devices

A4572	Rib belt	$9.78
4960A	Brace	Acquisition Cost

Miscellaneous Supplies

Effective for dates of service on and after July 1, 2002, HCPCS code A4550 is bundled.

~~A4550~~	~~Surgical trays~~	
A4561	Pessary rubber, any type	Acquisition Cost
A4562	Pessary, nonrubber, any type	Acquisition Cost
A4565	Slings	$6.21
A4570	Splint	$14.52
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code. **(To be used only for cochlear implant replacement parts. Prior authorization is required for the replacement parts and will be manually priced by MAA's authorization department.)**	B.R.
L8600	Breast implants	$650.00
1949M	Tissue expander implant	$950.00
L3807	WHFO, extension assist, with inflatable palmer air support, with or without thumb extension	Acquisition Cost
L9900	Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS "1" code	Acquisition Cost

Supplies for Radiologic Procedures

A4641	Supply of radio-pharmaceutical diagnostic imaging agent, not otherwise classified	Acquisition Cost
A4642	Supply of satumomab pendetide, radiopharmaceutical diagnostic imaging, per dose	Acquisition Cost

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting
A4643	Supply of high high dose contrast material(s) during magnetic resonance imaging, e.g., gadoteridol injection, (consistent with contrast labeling criteria) Separate payment will be allowed for high dose contrast material when expedited authorized third magnetic resonance imaging (MRI) is performed.	Acquisition Cost
A4644	Supply of Low Osmolar Contrast Material (100-199 mgs of iodine) Brand Name — Generic Name Omnipague 140 and 180 — Iohexal Optiray 160 — Ioversol	Acquisition Cost
A4645	Supply of Low Osmolar Contrast Material (200-299 mgs of Iodine) Brand Name — Generic Name Ominpaque 210 and 240 — Iohexal Optiray 240 — Ioversaol Isovue 200 — Iopamidol	Acquisition Cost
A4646	Supply of Low Osmolar Contrast Material (300-399 mgs of Iodine) Brand Name — Generic Name Omnipaque 300 and 350 — Iohexal Hexabrix — Ioxaglate Optiray 320 — Ioversol Isovue 300 Ultravist	Acquisition Cost
A4647	Supply of paramagnetic contrast material (e.g., gadolinium)	Bundled
A9500	Supply of radiopharmaeutical diagnostic imaging agent, technitium tc 99M sestamibi, per dose	$80.00
A9502	Supply of radiopharmaceutical diagnostic imaging, technetium tc 99M, tetrofosmin, per unit dose	Acquisition Cost
A9503	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc 99M, medionate, up to 30 MCI	Acquisition Cost
A9504	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc 99M, apcitide	Acquisition Cost
A9505	Supply of radio-pharmaceutical diagnostic imaging agent, thallous cloride TL 201, per MCI	$34.00
A9507	Supply of radiopharmaceutical diagnostic imaging agent, indium in 111 capromab pendetide, per dose	Acquisition Cost
A9508	Supply of radiopharmaceutical diagnostic imaging agent, iobenguane sulfate I-131, per 0.5 mCi	Acquisition Cost
A9510	Supply of radio-pharmaceutical diagnostic imaging agent, technetium TC99M disoferin, per vial	Acquisition Cost
A9600	Supply of therapeutic radiopharmaceutical, strontium-89 chloride, per MCI	Acquisition Cost
A9605	Supply of therapeutic radio pharmaceutical samarium sm 153 lexidronamm, 50 mcl	Acquisition Cost

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting
A9700	Supply of injectable contrast material for use in echocardiography, per study	Acquisition Cost
Q3001	Radioelements for brachytherapy, any type each	Acquisition Cost
Q3002	Supply of radio-pharmaceutical diagnostic imaging agent, allium GA 67, per mCi	Acquisition Cost
Q3003	Supply of radio-pharmaceutical diagnostic imaging agent, technitium Tc 99m	Acquisition Cost
Q3004	Supply of radio-pharmaceutical diagnostic imaging agent, xenon XE 133, per 10 mCi	Acquisition Cost
Q3005	Supply of radio-pharmaceutical diagnostic imaging agent, technetium Tc 99m mertiatide, per mCi	Acquisition Cost
Q3006	Supply of radio-pharmaceutical diagnostic imaging agent, technetium Tc 99 glucepatate, per 5 mCi	Acquisition Cost
Q3007	Supply of radio-pharmaceutical diagnostic imaging agent, sodium phosphate P32, per mCi	Acquisition Cost
Q3008	Supply of radio-pharmaceutical diagnostic imaging agent, indium 111 – in pentetreotide, per 3 mCi	Acquisition Cost
Q3009	Supply of radio-pharmaceutical diagnostic imaging agent, technetium Tc 99m oxidronate per mCi	Acquisition Cost
Q3010	Supply of radio-pharmaceutical diagnostic imaging agent, technetium Tc 99m – labeled red blood cells, per mCi	Acquisition Cost
Q3011	Supply of radio-pharmaceutical diagnostic imaging agent, chromic phosphate P32 suspension, per mCi	Acquisition Cost
Q3012	Supply of oral radio-pharmaceutical diagnostic imaging agent, cyanocobalamin cobalt Co57, per 0.5 mCi	Acquisition Cost

Metered Dose Inhalers and Accessories

Effective for claims with dates of service on and after November 1, 2001, state-unique codes 4992A and 4993A are discontinued. ***Please use HCPCS code A4627.***

State-unique code 6645E is discontinued. Please use HCPCS code A4614.

A4614	Peak flow meter	$24.29
A4627	Spacer bag, or reservoir, with/ without mask (for use with metered dose inhaler)	$23.70

Inhalation Solutions

J7610-J7699 (See Section L.)

Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting	Procedure Code	Description	Maximum Allowable Fee Non-Facility Setting/ Facility Setting

Urinary Tract Implants

Urinary tract implants, listed below, are covered only for treatment of type III stress urinary incontinence resulting from intrinsic sphincter deficiency (ISD) (ICD-9-Dx code 599.82). **The procedure and drug DO NOT require prior authorization, but are limited.** See below and Section I.

Prior to prescribing urinary tract implants, the physician must:

- Have urology training in the use of a cystoscope and must have completed a urinary tract implant training program for the type of implant used.
- Document that the client has shown no incontinence improvement through other therapies for at least 12 months prior to collagen therapy.
- Administer and evaluate a skin test for collagen sensitivity over a four-week period prior to collagen therapy. A negative sensitivity must be documented in the client's record.

All services provided must be billed on the same claim form:

- CPT code 95028 – skin test for collagen sensitivity; only one is allowed — $5.38

Effective for dates of service on and after July 1, 2002, HCPCS code G0025 is bundled.

- ~~HCPCS code G0025 Collagen skin test kit~~

- CPT code 51715 – Implant procedure
  - Non-Facility Setting — $190.65
  - Facility Setting — $118.07

- HCPCS code L8603 — $333.13
  Collagen implant, urinary tract, per 2.5 ml syringe

- HCPCS code L8606 — $170.87
  Synthetic implant, urinary tract, per 1 ml syringe

NOTE: If the implants are done outside the physician's office, then L8603 and L8606 are not allowed.

MAA will cover the first three (3) implants only, using an combination of L8603 and/or L8606, per client. Each 2.5 ml syringe of L8603 or each 1 ml syringe of L8606 is 1 implant.

- **All invoices must be retained in the physician's office for supplies that cost less than $50.00 and must be made available to MAA upon request.**
- **All invoices must be submitted to MAA for supplies that cost $50.00 or more.**

This is a blank page.